Request for Review by Unified Planning Team
Pursuant to M.G.L. ch. 6A, § 16R

A Unified Planning Team (UPT) is an interagency team that collaborates to review complex cases of children up to 22 years of age. Please complete the following form to request a review by a Unified Planning Team.

Date of this Request: ___________________________

Background Information

1. The Child whose case the Unified Planning Team is being requested to review

Name ____

Date of Birth _________________Age ____________________

Current Address ____

2. The Child's Legal Custodian (for example, parent or legal guardian). If the child is his or her own legal custodian, please check here ___

Name ____

Address ____

Telephone ____

Email address ____

3. The Person Submitting this Request for Review by a Unified Planning Team

- ❒ I am the child in Question 1 above and am authorized by law to request a review of my own case.
- ❒ I am the child's legal custodian in Question 2 above.
- ❒ I am a justice of a Massachusetts Juvenile Court.

  Name ____

  Court ____

  Telephone ______________________________________

  Email address ___________________________________
- ❒ I am a representative of a Massachusetts state agency and my agency has designated me to provide referrals requesting review by a Unified Planning Team.

  Name ____

  Agency ____

  Telephone ______________________________________

  Email address ___________________________________

State Agency Involvement

A Unified Planning Team collaborates when a child may qualify for services from multiple state agencies. Please list below the state agencies with which the child is currently involved or has a pending application:

Name of State Agency ______________________________________

Contact person and
telephone number (if applicable) ______________________________________

Name of State Agency ______________________________________

Contact person and
telephone number (if applicable) ______________________________________

Name of State Agency ______________________________________

Contact person and
telephone number (if applicable) ______________________________________

Name of State Agency ______________________________________

Contact person and
telephone number (if applicable) ______________________________________

Name of State Agency ______________________________________

Contact person and
telephone number (if applicable) ______________________________________

Educational Background

1. Does the child attend school? Yes _____ No _____

2. If you answered yes to the prior question, please provide the following information:

   Name of school district: ______________________________________

   Name and address of school: __________________________________

   ____

3. If the child receives special education services, please check here: ____

Request for Review by a Unified Planning Team

Please briefly tell us why you are requesting a review by a Unified Planning Team.

____

Are you working with an Attorney or Guardian Ad Litem (GAL) ? If so please provide contact information below:

Name of Atorney/GAL ____

Agency ____

Telephone ____

Email address ____

Please review the attached consent form and send it, along with this completed form, to the address below.

Office of Children, Youth and Families
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

CONSENT TO SHARE PERSONAL INFORMATION

CHILD'S NAME: _________________________
DATE OF BIRTH: _____________

A Unified Planning Team is a geographically based, interagency review team consisting of state agency representatives based on the needs of the child. The goal of a review by a Unified Planning Team is for representatives from different agencies to collaborate on complex cases.

This Consent concerns the sharing of personal information among the Executive Office of Health and Human Services (EOHHS), the Secretary of EOHHS, agencies within EOHHS, the Department of Secondary and Elementary Education (DESE), and the Department of Early Education and Care (DEEC) to the extent these parties are involved in a review by a Unified Planning Team. This Consent also concerns the sharing of personal information with the Division of Administrative Law Appeals (DALA), when applicable.

In providing or paying for health and human services, EOHHS, its agencies, and other state agencies, collect personal information about individuals and their families. The agencies keep such information confidential and only use or disclose it as permitted by law. This Consent is sought so that the Unified Planning Team may obtain and discuss this personal information in order to complete a fully coordinated review. The information will be used and disclosed, in accord with applicable privacy laws, to complete the Unified Planning Team review.

The agencies asking for consent through this form are:

- ❖ Executive Office of Health and Human Services, its Secretary, and the agencies within EOHHS, including the Office of Medicaid (MassHealth);
- ❖ Department of Elementary and Secondary Education (DESE);
- ❖ Department of Early Education and Care (DEEC); and
- ❖ Division of Administrative Law Appeals.

The client information to be shared, either in case discussions, or in writing, or electronically, is:

- ❖ Personal information needed to complete a coordinate Unified Planning Team review. This may include, but not be limited to, educational, employment, financial, and health (physical and behavioral) information, including medical records or any evaluation or assessment of the child, as well as information about family and community supports, services that may be needed or that are being provided by the agencies listed above or by other agencies.
- ❖ EOHHS state agency and MassHealth eligibility information
- ❖ MassHealth claims

  The information MassHealth shares with the EOHHS agencies under this consent may be re-disclosed and no longer protected by the HIPAA

Privacy Rule. But each such agency will only use or disclose the information it receives in accord with confidentiality laws applicable to it.

By giving permission to share information noted above, please indicate whether you are giving permission to share any drug and alcohol treatment information:

_____**Yes**, share drug and alcohol treatment information
_____**No**, do not share drug and alcohol treatment information

May we share information with the child's Local Education Authority/school?
_____**Yes**
_____**No**

This consent will expire in 12 months unless a specific expiration time is inserted here: (insert the date, time period or an event to end the consent):
__________________________.

The person signing below may cancel this consent at any time by sending a written cancellation to: Children, Youth and Families Executive Office of Health and Human Services 1 Ashburton Place 11th floor, Boston, Mass. 02108. Any such cancellation will not apply to information that has already been released pursuant to this consent.

This consent must be signed by an individual with authority to sign on behalf of the child. This individual may be a parent or legal guardian or, if authorized by law, may be the child himself. The person signing below gives this consent voluntarily. If such person decides not to give consent or gives consent but later cancels it, such person or the child or person on whose behalf consent is given will still be able to receive any treatment or benefits to which such person is entitled. However, the Unified Planning Team will not be able to complete its review.

A copy of the signed Consent was given to the person signing below.

____
Signature of Child or Child's Personal Representative

____
Printed Name of Person Signing

____
Date

IF SIGNED BY A PERSONAL REPRESENTATIVE (that is**,** someone who has the legal authority to act on behalf of the individual, such as a parent of a minor child, or a legal guardian), **please indicate below the type of legal authority you have for signing the Consent**:
_______ **Custodial Parent**
_______ **Legal Guardian (attach court order)**
_______ **Other (attach proper documentation)**